25, married 3 years, mother of two children, last child one year ago. She began to menstruate at 12, but was never regular. She was married at 22 and became pregnant soon after. Shortly before the first baby was born, she had a pain in her left side, which was thought to be pleurisy, although she pointed to a spot in the left iliac region as the site of the pain, which leads me to think that the so-called pleurisy was pelvic peritonitis,—a belief which is strengthened by the appearance of old and dense organized adhesions between the ovary and tube on that side. Her first labor was a severe one, necessitating the use of forceps. During the next two years she had several attacks of "pleurisy," for which she was treated by several different physicians. Every time she did a little extra work about her house she was laid up with an attack, always in left ovarian region. Five weeks before coming under my notice she was suddenly taken with a very severe pain in her left side and a fainting fit while walking on the street. She was brought home in a cab. She then began to flow, and continued flowing ever since, rather profusely. She was sure it was not a miscarriage, because she had not missed a period. After a few days she was able to get up again, but two weeks later had another fainting fit following a severe, sharp, cutting pain. Again, the same thing occurred one week before I saw her, since which she had to keep to bed With the second and third attacks she vomited. She then called in a physician (who happened to be one of my former students), who examined her, and found a badly lacerated cervix and very large and tender appendages. He called me in consultation, when I found a mass the size of a small orange in Douglas' cul-de-sac, which was exceedingly sensitive to pressure. I at once diagnosed tubal pregnancy, told her physician so, and urged immediate operation. I based my diagnosis merely on the sudden and cutting character of the pain and the vomiting and fainting in the street, coupled with a continuous flow during five weeks. She entered my private hospital, and on the 20th October I removed this beautiful specimen. In order to make her recovery a satisfactory one in every respect, I dilated and curetted the uterus, and sewed up the cervix at the same sitting, previous to the abdominal section ; and as the uterus was retroverted, I performed ventrofixation after the removal of the appendages. The five operations of dilating, curetting, repairing the cervix, removing the appendages and attaching the uterus to the abdominal wall, occupied one hour and ten minutes. Only two ounces of A.C.E. mixture were used. Since Dr. Gordon Campbell read his excellent paper on ether, I have been following his example and have been keeping an exact record of the quantity of A.C.E. mixture used and the number of minutes consumed. I will have some surprising facts to lay before you. For instance, I have several times performed from three to five operations with an expenditure of only one ounce and a half of A.C.E. mixture. The dates of the various hemorrhages was beautifully illustrated when the specimen was first removed by the clots of blood surrounding it. There was rather bright red blood recently escaped, dark and slightly organized clots, and old, hard clots very dense and firm. When washing the specimen the more recent clots washed off ; also several soft clots were sponged out of the abdomen, which was, however, closed without irrigation or drainage.

A few points may be raised for discussion. Why did I curette the uterus? 1st, Because it was large and heavy ; and 2nd, because I wished to be able to assure you that there was no uterine abortion there. Why did I repair the cervix at the same sitting? Because I have found it very difficult to get the patient to go through a second operation if she has not been